MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND
OPEN PLAN REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2006

PLEASE PRINT

Official Use Only

Log No: _____

Optical: _____

Total: _____

Employee Name: _____
Last First MI

Address: _____
Street PO Box/Apt # City State Zip

Work (___) _____ Ext ___

Phone: Home (___) _____

E-MAIL ADDRESS_____

Name of Dept./ Agency/Authority: _____

Name of Employee's Health Insurance: _____

Month _____ Day _____ Year _____ is my start date in a MOSES represented title.

YES ☐ NO ☐ Did you leave your MOSES represented title at any time during Calendar Year 2006?
YES ☐ NO ☐ Did you work less than 37.5 hrs/week in your MOSES represented title at some time during Calendar Year 2006?
YES ☐ NO ☐ Are you retired? If YES, show Retirement date _____
YES ☐ NO ☐ Are you enrolled under COBRA?
YES ☐ NO ☐ Were you on Worker's Compensation or unpaid leave of absence (excluding furlough) from your MOSES represented title at any time during Calendar Year 2006? If YES, show dates _____
YES ☐ NO ☐ Are you or any recipients entitled to dental or optical benefits under a health plan other than the one named above? _____ **Plan Name**
YES ☐ NO ☐ Were you or any recipients injured by a Third Party's wrongful act or negligence?
YES ☐ NO ☐ Have you made any other submission for Calendar Year 2006 services?

✓ **If you answer YES to any question above, provide dates if applicable and attach additional details.**

Attach original statements from Doctor/Vendors showing: ***the name, address and telephone number*** *of the service provider; the service recipient; date of service; and proof of payment for each entry listed below.*
***** These services must have been rendered during Calendar Year 2006. *****

Recipient of Service	Relationship Proof of dependent status must be provided upon request. For dependent students age 19 – 23, provide verification from school.	Date of Birth	Service Provided	Date of Service	Cost of Service	Amount Paid Attach Receipts
DENTAL						
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
OPTICAL						
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Single Lenses ☐ Bi/Tri Focal Lenses ☐ Regular Contacts ☐ Disposable Contacts ☐			
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Single Lenses ☐ Bi/Tri Focal Lenses ☐ Regular Contacts ☐ Disposable Contacts ☐			
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Single Lenses ☐ Bi/Tri Focal Lenses ☐ Regular Contacts ☐ Disposable Contacts ☐			

☞ **You must answer all questions and provide all required information and attachments or your application will be returned unprocessed; subsequent resubmissions will be assessed a $9.50 reprocessing fee.**

Total: $ _____

I hereby certify under the penalties of perjury that I have read the Plan printed on the back of this form, have provided all requested information, and that all information provided meets the requirements of the Massachusetts / MOSES Health and Welfare Trust Dental/Optical Aid Plan; that I have not requested reimbursement for payment for these same services from any other plan, except as allowed by this Plan; and that information submitted is true and accurate to the best of my knowledge. I understand that if I make a material misrepresentation I may lose all rights to participate in this program and be liable for recovery costs of reimbursements improperly made.

Note: Send the completed reimbursement request and all necessary attachments to:

ADMINISTRATOR
MASSACHUSETTS / MOSES HEALTH & WELFARE TRUST
P O BOX 252
NORTH READING, MA 01864-0252

SIGNATURE _____

EMPLOYEE ID NUMBER _____
(From your timesheet or check stub)

DATE _____

The full Calendar Year 2006 Plan is detailed on the back of this form.

MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND
OPEN PLAN REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2006

This Plan reimburses an eligible employee for covered expenses incurred by the employee and his/her eligible dependent(s) when such expenses are not provided by another source. This Plan may cover former employees and ineligible dependent(s) under COBRA (See Termination of Coverage).

REIMBURSEMENT FORMULA

The maximum family reimbursement for full-time employees for services provided during Calendar Year 2006 is **$2,550**. The reimbursement formula for full-time employees is 100% of the first $800 plus 50% of the next $2,800 plus 25% of the next $1400 in covered expenses. However, not more than $600 in optical services including exams is reimbursable. Expenses for optical services will be pro-rated before the formula is applied. Reimbursement for employees new to the Unit will be prorated based upon the length of service in the benefit year.

For part-time employees the above formula is pro-rated based on work hours. For example, the reimbursement formula for half-time employees is 100% of the first $400 plus 50% of the next $1400 plus 25% of the next $700 in covered expenses.

COVERED EXPENSES

TYPE OF SERVICE	COVERED SERVICES	AMOUNT COVERED	REIMBURSEMENT AMOUNT
DENTAL SERVICES			
Dental and Orthodontic Services	Any work provided by a legally qualified Dentist or Orthodontist, except bleaching or similar services.	Actual out of pocket receipted expenses.	100%
OPTICAL SERVICES (including EXAM) **(Maximum Optical Reimbursement Amount is $600.)**			
Optical Exam	Any vision examination provided by a legally qualified optometrist or ophthalmologist.	Actual out of pocket receipted expenses, not to exceed $100. per visit, HMO, POS and PPO Enrollees: $15 Limit per visit	100%
Glasses (Single lens, Bi/Tri Focal)	Products provided by a legally qualified optometrist, ophthalmologist, or optician, except as noted below.	Up to $ 300.00 maximum per pair	80%, Up to $240.00 max/pair
Regular Contact Lenses		Up to $ 200.00 maximum per lens	80%, Up to $160.00 max/lens
Disposable Contact Lenses	Show on receipt if contact lenses are disposable.	Up to $ 200.00 maximum per year	80%, Up to $160.00 max/year
The following optical services and items are NOT covered: Non Prescription Sunglasses; Prescription Sports Goggles; Medicines; Laser Treatments; Vision Therapy; Eye Training; and Surgery such as Radial Keratotomy.			

EMPLOYEE ELIGIBILITY

As used in this Plan, the term "employee" means a full-time or regular part-time person employed in a MOSES represented title. A full-time employee is defined as an employee who normally works a full week and whose employment is expected to continue for twelve months or more, or an employee who normally works a full week and who has been employed for twelve consecutive months or more. A regular part-time employee is defined as an employee who is expected to work 50% or more of the hours in a work year of a regular full-time employee in the same title. An employee is eligible for benefits after contributions have been paid on his/her behalf to the trust fund for six consecutive months. If an employee has worked for six previous months in another Unit, which waives the eligibility waiting period for Unit Nine employees, he/she shall be immediately eligible for benefits under this Plan. In no case will reimbursement be made for services provided before the first day of eligibility.

DEPENDENT ELIGIBILITY

An employee's eligible dependents include his/her spouse and unmarried children from birth to age 19. Unmarried children who are age 19 to 23 are also eligible if wholly dependent upon an employee for support and maintenance while a full-time student in school or college. Proof of dependent status must be provided upon request. Proof of student status from the school must be provided with your application. Coverage for an unmarried child, more than half of whose support and maintenance is provided by the employee, and who is incapable of self-sustaining employment because of mental disability or physical handicap and whose incapacity began prior to age 19 shall continue as long as the employee's coverage remains in force and said incapacity continues.

TERMINATION OF COVERAGE

Coverage under this Plan terminates when the employee leaves Unit Nine except that a former employee may be entitled to retroactive reimbursement for expenses incurred while in Unit Nine on a ratio of the employee's service to a full calendar year's service. COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1986) provides a procedure by which a former employee and/or an ineligible dependent of a present employee may continue coverage, for a limited time, upon payment of appropriate fee. To receive benefits under COBRA you must apply in writing to the Administrator, Massachusetts / MOSES Health and Welfare Trust Fund within 60 days of your eligibility for extended coverage, or the eligibility of your dependent(s), as detailed above.

COORDINATION OF BENEFITS

If an employee or his/her dependent is entitled to benefits under any other plan which will provide part or all of the benefits paid under this Plan, the employee is required to submit the name of the other plan and any amounts received so that the benefits payable under this Plan added to amounts from other plans will not exceed 100% of the expenses incurred.

The term "other plan" means any plan providing benefits or services covered under this Plan, that is: (A) group or blanket insurance coverage; (B) group Blue Cross/Blue Shield, Indemnity Plan or health maintenance organizations (HMO) and other pre-payment coverage provided on a group basis; (C) any coverage under labor-management plans, union welfare plans, employer organization plans, employee organization benefit plans or any arrangement of benefits for individuals or group; (D) any coverage under government program; (E) any coverage required or provided by any statute; and (F) any non-group plan.

SUBROGATION

If an employee or his/her dependent(s) is injured because of a third party's negligence:

A. Benefits will be payable under the Plan for that injury, subject to the condition that the employee and his/her dependent (if applicable):
   1. Agrees to the Massachusetts / Moses Health and Welfare Trust Fund (herein known as the Fund) being subrogated to any recovery or right to recover against the third party;
   2. Will not take any action which would prejudice the Fund's subrogation rights; and
   3. Will cooperate in doing what is reasonably necessary to assist the Fund in any recovery.

B. The Fund will be subrogated to the extent Plan benefits were paid because of that injury.

BOARD OF TRUSTEES' STATEMENT

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan whenever, in its judgment, conditions so warrant. Only the Board of Trustees, or a designee acting on its behalf, has the authority to determine eligibility for benefits and the right to participate in this Plan. Correspondence to the Board of Trustees, should be addressed to Massachusetts / MOSES Health and Welfare Board of Trustees,
90 North Washington Street, Boston, MA 02114.

EFFECTIVE DATES

No reimbursement for services provided before January 1, 2006 or after December 31, 2006 will be allowed.

All claims must be submitted on this form.

Submit to: Administrator - Massachusetts / MOSES Health and Welfare Trust Fund
PO Box 252
North Reading, MA 01864-0252

Attach original itemized statements from Doctor/Vendor showing in detail the name, address and telephone number of the service provider, the recipient, the services provided, dates of service, and proof of payment. Please keep copies of all submitted materials.

Reimbursement Requests for Calendar Year 2006 must be postmarked no later than June 30, 2007.

Please allow up to ten weeks for processing. If you desire a confirmation of receipt of your request form, address and apply postage to the enclosed card and include it with your application. Requests for additional forms or questions should be referred to the Fund Administrator by mail at the address listed above, by telephone (voicemail) @ 978-664-1634, or by e-mail at moses-hwtf@verizon.net .